EPPM Goal Recommendations for New Areas of Consideration for the QCC							
Goal	**Measure Recommendation**	**2008**	**2009**	**2010**	**2011**	**2012**	**National Benchmark**
1. Reduce the cost of health care.	Rate of growth in spending by Medicaid, Medicare, commercial insurers, self-insured plans						
	Consumer cost sharing as a precentage of total premiums						
	Employee contributions toward premiums						
	Individual		28%				
	Family		32%				
	Percentage of inpatient hospitalizations for all payers that are estimated to have been preventable	8%					10%
	Inpatient days per 1,000 population	688.5					657.3
	Inpatient beds per 1,000 population	2.5					2.7
	Percent of total lives covered under risk-contracting arrangements						
2. Ensure patient safety and effectiveness of care.	**Hospital Readmissions**						
	Short-stay nursing home residents with a hospital readmission within 30 days	19.5%					20.8%
3. Improve screening for and management of chronic illnesses in the community.	**Preventive Care**						
	Children 19-25 months with recommended vaccines	91.1%					85.7%
	Children 3-6 years who saw their PCP in the past year	92.7%					72.2%
	Adults who did not visit the dentist in the past year	20.7%					28.7%
	White	20.8%					26.5%
	Black	29.5%					38.1%
	Hispanic	28.4%					38.9%
	Children who did not visit the dentist in the past year	16.2%					21.6%
	White	13.8%					19.1%
	Black	18.0%					21.7%
	Hispanic	26.2%					28.5%
	Women (40+) who have had a mammogram in the past two years	87.3%					79.5%
	White	84.8%					75.9%
	Black	86.6%					79.3%
	Hispanic	88.6%					73.5%
	Adults (50+) who have ever had a sigmoidoscopy or a colonoscopy	71.4%					62.2%
	High risk nursing home patients with pressure sores	10.9%					11.5%
	Behavioral/Mental Health						
	Children who received needed mental health care in the past year	66.6%					63.0%
	Antidepressant medication management (% of patients diagnosed with depression who filled a prescription for at least a 3-month supply of their medication)	66.8%					63.1%

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4. Develop and provide useful measurements of health care quality in areas of health care for which current data are inadequate.	**Care Transitions**						
	Follow-up after hospitalization for mental illness						
	MA skilled nursing facilities participating in the Advancing Excellence Program who use the "Advance Care Planning Module"						
5. Eliminate racial and ethnic disparities in health and in access to and utilization of health care; health indicators will be consistent, and consistently improving, across all racial and ethnic groups.	Consider analyzing goals by income/SES as well as race/ethnicity						
6. Promote quality improvement through transparency.	Patients who access medical records through an online portal						